STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155359	A. BUILDING _____ B. WING _____	R-C 04/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERBEND HEALTH CARE CENTER	7519 WINCHESTER ROAD FORT WAYNE, IN 46819

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS This visit was for a Post Survey Revisit (PSR) to Complaint Number IN00086999 and Complaint Number IN00087008 completed on March 14, 2011. This visit was in conjunction with the investigation of Complaint Number IN00088238. Complaint Number IN00086999 and Complaint Number IN00087008 corrected Survey dates: April 18, 19, 20, 2011 Facility number: 000250 Provider number: 155359 Aim number: 100289980 Survey team: Ann Armey, RN Census bed type: SNF/NF: 50 Total: 50 Census payor type: Medicare: 7 Medicaid: 38 Other: 5 Total: 50 Sample: 9 Riverbend Health Care Center was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2 in regard to the Post Survey Revisit (PSR) to Complaint Number IN00086999 and Complaint Number IN00087008.	{F 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155359	A. BUILDING _____ B. WING _____	R-C 04/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERBEND HEALTH CARE CENTER	**7519 WINCHESTER ROAD FORT WAYNE, IN 46819**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	Continued From page 1 Quality review completed 4-26-11 Cathy Emswiller RN	{F 000}		